SOUTH DAKOTA BOARD OF NURSING
4305 SOUTH LOUISE AVENUE, SUITE 201
SIOUX FALLS, SD 57106-3115
TEL (605) 362-2760 FAX (605) 362-2768

APPLICATION FOR MEDICATION ADMINISTRATION TRAINING PROGRAM FOR UNLICENSED ASSISTIVE PERSONNEL

in accordance with ARSD 20:48:04.01

Please select: ❒INITIAL APPROVAL APPLICATION ❒REAPPROVAL APPLICATION

NAME OF FACILITY: _____

ADDRESS: _____

FACULTY REPRESENTATIVE: _____ TELEPHONE: _____

EMAIL: _____ FAX: _____

NAME OF MEDICATION ADMINISTRATION COURSE: _____

CURRICULUM

INITIAL APPROVAL REQUIREMENTS	REAPPROVAL REQUIREMENTS
❑ If using a Curriculum that has current Board of Nursing approval, you are not required to submit that Curriculum	❑ Submit Curriculum changes, if any ❑ Submit Faculty changes, if any
❑ If using a curriculum that does not have current Board of Nursing approval, submit Curriculum Materials	COMMENTS:

NOTE: Written notification should be submitted to the Board of Nursing if any substantive changes in Curriculum or Faculty are made within the two-year Approval Period.

NAMES OF FACULTY MEMBERS

Qualifications of Faculty Members:

❒ Attach Vitae/Professional Work History when **first** submitting credentials for faculty approval

❒ Attach a copy of current RN license with **every** application (Initial Approval and Reapproval)

TO BE COMPLETED BY RN FACULTY

These standards reflect South Dakota Administrative Rules **ARSD 20:48:04.01 13-15** with which medication administration training programs must comply. Explain any "no" response(s) on a separate sheet of paper.

1. Program is no less than 16 classroom hours and no less than 4 hours of clinical/laboratory instruction	YES	No
2. Person teaching a training program is a registered nurse who is currently licensed in South Dakota and has a minimum of two years clinical nursing experience	YES	No
Faculty to student ratio does not exceed 1:8 in the clinical setting	YES	No
1:1 ratio is required for skills performance evaluation	YES	No
3. Tests are developed for each unit, including a final test	YES	No
Skills performance evaluation is conducted	YES	No
4. A passing test score of 85% is required.	YES	No
5. Unit exam retakes allowed no more than one time	YES	No
6. A completion certificate is awarded stating name and location of the institution	YES	No
Length of program	YES	No
Course completion date	YES	No
Full name of person completing course	YES	No
Signature of faculty in charge of course	YES	No
Date awarded	YES	No
7. Records are maintained documenting:	YES	No
Each person enrolled	YES	No
Documentation of performance	YES	No
Date and reason person withdrew or date person failed or completed the program	YES	No
Each faculty member teaching the program, including qualifications and nursing experience	YES	No
Curriculum plan and revisions	YES	No
All tests administered	YES	No
List of graduates of program who were awarded certificates and date of award	YES	No
8. Each person enrolled/completing the training has either a high school diploma or equivalent	YES	No
9. Training curriculum for delegated medication administration must include general information relevant to the administration of medications, including:	YES	No
Governmental regulations related to the practice of nursing, the administration of medication, and the storage, administration, and recording of controlled substances	YES	No
Ethical issues	YES	No
Terminology, abbreviations, and symbols	YES	No
Medication administration systems	YES	No
Forms of medications	YES	No
Procedures and routes of medication administration	YES	No
Medication references available	YES	No
Role of unlicensed assistance personnel in medication administration	YES	No
Five rights of medication administration: right patient, right medication, right dose, right time, right route	YES	No
10. Infection control policies and procedures	YES	No
11. Overview of major categories of medications related to body systems	YES	No
12. Additional instruction shall include categories of medications relevant to the health care setting where unlicensed person will be employed	YES	No

RN Faculty Signature: _____ **Date:** _____

THIS SECTION TO BE COMPLETED BY SOUTH DAKOTA BOARD OF NURSING REPRESENTATIVE

DATE THAT THIS APPLICATION WAS RECEIVED:

APPROVED: APPROVAL EXPIRATION DATE:

DENIED: REASON FOR DENIAL:

RETURNED:

Board of Nursing Representative/Signature: _____